CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Metropolitan Gastroenterology Group

AUTHORIZATION FOR TRANSFER OF MEDICAL INFORMATION

Patient's Name _____ _____/_____/_____
(PLEASE PRINT) First M.I Last Date of Birth

Patient's Contact Information: _____
Street Address City, State, Zip Telephone Number

I hereby authorize:

Capital Digestive Care / Metropolitan Gastroenterology Group

To transfer information to:
MedStar Washington Hospital Center / I. David Shocket, MD

110 Irving Street, NW
Street Address

Fax Number: 202-877-8163

Washington, DC 20010
City, State and Zip Code

Phone Number: 202-877-7108

Information to be transferred:

In accordance with Meaningful Use Stage 2 Requirements §495.6(I)(11)(ii)(B)) Capital Digestive Care can provide to any Centers for Medicare & Medicaid Services (CMS) certified electronic health (EHR) application an electronic Transition of Care (TOC) document that may include the following: patient name, transition provider's name, procedures, encounter diagnosis, immunization, lab results, vital signs, smoking status, functional status, demographic information, care plan field, care team, discharge instructions, current problem list, current medication list, and current medication allergy list. It is the responsibility of the receiving EHR to meet the same requirements as outlined in this core Meaningful Use measure in order for Capital Digestive Care to send the TOC document electronically.

Additional information will be provided upon request.

Capital Digestive Care Metropolitan Gastroenterology Group

Martin Bashir, MD
George Bolen, MD
Kevin P. Collier, MD
Richard Gelfand, MD
Howard Goldberg, MD
Robert Hardi, MD
Dominique Howard, MD
Peter Kaufman, MD
Michael Keegan, MD
Kathryn Kirk, MD
Jonathan Koff, MD
Jessica Korman, MD
Louis Korman, MD
Donald O'Kieffe, MD
Eric Pollack, MD
Julio Salcedo, MD
Michael Schwartz, MD
Amy Shah, MD
Michael Weinstein, MD
Lawrence Widerlite, MD
Laure Kouyoudjian, PA-C
Jillian Sarles, PA-C
Kristin Villa, PA-C

WASHINGTON, DC
2021 K St, NW
Suite 500
202.296.3449 PHONE
202.296.0301 FAX

106 Irving St, NW
Suite 205S
202.829.0170 PHONE
202.829.2927 FAX

CHEVY CHASE, MD
5550 Friendship Boulevard
Suite T-90
Chevy Chase, MD 20815

301.654.2521 PHONE
202.296.0301 FAX

BETHESDA, MD
10215 Fernwood Rd
Suite 404
Bethesda, MD 20817

301.493.5210 PHONE
202.296.0301 FAX

capitaldigestivecare.com

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I understand that Maryland Law 4-304©(3) allows medical providers to charge a fee for duplication of medical records and any related administrative services. I understand that the medical records to be released may contain protected health information (PHI) related to Hepatitis, HIV Status, AIDS, Sexually Transmitted Diseases, alcohol or drug use, or mental health services; and hereby authorize the release of this information. All information released will be handled confidentially. This authorization for disclosure is specific for this request only and is valid for one year from the date of this authorization release***. I may withdraw this authorization at any time except to the extent that action has been taken in response thereon.***

Signature of Patient	Date	Signature of Parent/Guardian	Relationship

Please submit completed form to Metropolitan Gastroenterology Group c/o Yvette Robertson
E: Yvette.Robertson@capitaldigestivecare.com F: 202.296.0301 P: 301.654.2521

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